

addition to the time factor is more than one epidural catheter.

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## REPLY

*Drs. Rozenberg, Isserlish and Birkhan have missed the point of our case report. It was not intended to convey the message that bilateral interpleural block (BIPB) combined with light general anaesthesia was our technique of choice for all patients undergoing midline upper abdominal surgery. Rather, it showed that BIPB combined with light general anaesthesia in our patient, provided good intraoperative and postoperative analgesia with minimal physiological disturbance.*

*No one doubts that continuous epidural analgesia with light general anaesthesia is an effective and well-established technique which will provide excellent analgesia and muscle relaxation. Both techniques have different physiological profiles, a factor which can be exploited to the patient's best interests. In situations in which a decrease in afterload is undesirable such as aortic stenosis or hypovolaemia, BIPB may represent a safer alternative than epidural analgesia. Furthermore, in the presence of generalised sepsis or coagulopathy, the potential complications of epidural abscess or haematoma, resulting from axial anaesthesia, do not apply if BIPB is employed. Also, other undesirable effects associated with the use of epidural narcotics and local anaesthetics are avoided. These include pruritus, urinary retention, nausea and vomiting, drowsiness, respiratory depression, total spinal, and permanent neurological damage.*

*There is no evidence to substantiate the statement that the combined epidural-general technique is "probably safer" or associated with fewer complications than BIPB. If they are referring to the problem of air in the pleural space, we feel that the incidence of clinically important pneumothorax can be reduced, if not altogether eliminated, by paying attention to a few points; employing a technique which utilizes saline to locate the interpleural space,<sup>1,2</sup> avoiding nitrous oxide and inserting the catheter during spontaneous respiration. We are unsure what Drs. Rosenberg et al. mean by BIPB being "too much" for one patient. The block is technically easy to perform and interpleural catheters can be placed rapidly with minimal discomfort to the*

*patient. However, one needs to pay particular attention to the dosage of local anaesthetic with the bilateral technique to avoid toxic effects.*

*We feel it is important to maintain a broad view and an expanded armamentarium with judicious application of an appropriate technique in a given situation.*

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## Massive tongue swelling

To the Editor:

We would like to comment on the report by Grigsby *et al.*<sup>1</sup> describing a case of tongue swelling after uncomplicated general anaesthesia. The swelling was attributed to sensitivity to the glutaraldehyde used to clean their laryngoscope.

Swelling of the tongue alone need not implicate a "local reaction to an applied substance." As noted by the authors, a wheal-and-flare response to injected glutaraldehyde is not conclusive evidence of hypersensitivity as this chemical has direct irritant properties. Tongue swelling that "progressed to fill the entire oral cavity and force his mouth open" is the dramatic and classical picture of acute angioedema, as illustrated in the report of Self *et al.*<sup>2</sup> This entity is defined as well-demarcated cutaneous or mucosal swelling caused by oedema of the dermis and subcutaneous tissues.<sup>3</sup>

The patient described by the authors had a history of anaphylactic reaction to penicillin, and was taking captopril and cefotaxime. A 0.1% incidence of angioedema in patients using ACE inhibitors has been reported.<sup>4,5</sup> The head and neck are primarily affected and fatalities have occurred due to airway obstruction. Swelling of the tongue and floor of the mouth without laryngeal involvement, as in this case, has been reported.<sup>4,5</sup> Cefotaxime is chemically related to penicillin, one of the more common causes of angioedema,<sup>6</sup> and is also a plausible aetiology in this case.

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## Coughing after fentanyl

To the Editor:

We would like to comment on the conclusion by Phua *et al.*<sup>1</sup> that patients with raised intracranial pressure (ICP), open globe or history of reactive airways should have opioid premedication before *iv* fentanyl at induction of anaesthesia. The study excluded all patients with a history of reactive airways so this part of the conclusion appears to be speculative.

We agree with the recommendation that fentanyl should be used with caution in some patients with raised ICP. We have observed coughing in a young patient with an acute extradural haematoma and Glasgow Coma Scale of 8/15. At induction of anaesthesia, fentanyl 200 µg provoked coughing for about five seconds before being suppressed by the thiopentone which had been given immediately after the fentanyl. There were no sequelae but the coughing was unexpected and disconcerting. However, we would not recommend that patients with raised ICP should have opioid premedication which is avoided in neurosurgical anaesthesia because of the risks from possible hypercapnia. An alternative technique would be to give the induction agent before the fentanyl.

We have also noted a high incidence of coughing with methadone.<sup>2</sup> In a current study, 10 of 15 unpremedicated women had coughing after a bolus of methadone 0.25 mg · kg<sup>-1</sup> at induction of anaesthesia. The high lipid solubility of both methadone and fentanyl may be important factors in the mechanism for coughing.

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## *Pneumatocèle cérébrale après anesthésie péridurale en milieu obstétricale*

À la rédacteur :

Peu décrit dans la littérature, le pneumatocèle cérébral lié à une anesthésie péridurale est une pathologie de fréquence sous-estimée en obstétrique. De ce fait, le cas récemment rapporté par Ash,<sup>1</sup> incite à faire état d'une observation semblable.

Une primigeste est hospitalisée à terme pour saignement vaginal et diminution des mouvements fœtaux. Après examen clinique et échographique, une perfusion d'ocytocine est installée. Une heure plus tard, alors que la dynamique utérine est bonne et l'état fœtal satisfaisant, une péridurale est pratiquée sur la parturiente en position assise. Elle s'effectue au niveau de l'espace L<sub>4</sub>-L<sub>5</sub> à l'aide d'une aiguille de Tuohy de calibre 18 selon la technique du mandrin gazeux. Le repérage de l'espace péridural est difficile et dès la perte brutale de résistance, la patiente signale une violente céphalée et vomit. Malgré l'absence d'extériorisation du liquide céphalo-rachidien (LCR), une brèche dure-mérienne est suspectée et une autre ponction de niveau supérieur est pratiquée sans incident. La céphalée, jugée supportable par la patiente jusqu'à l'accouchement, s'aggrave en post-partum ; s'y associent des vomissements en jet, un brouillard visuel et une obnubilation. Le décubitus dorsal strict n'induit aucune amélioration et l'état général s'altère. Apyrexie et examen somatique normal conduisent à une tomodynamométrie crânienne (TDM). La présence d'air dans les ventricules latéraux et les carrefours ventriculaires est ainsi révélée (Figure). L'évolution est marquée par l'amendement des signes